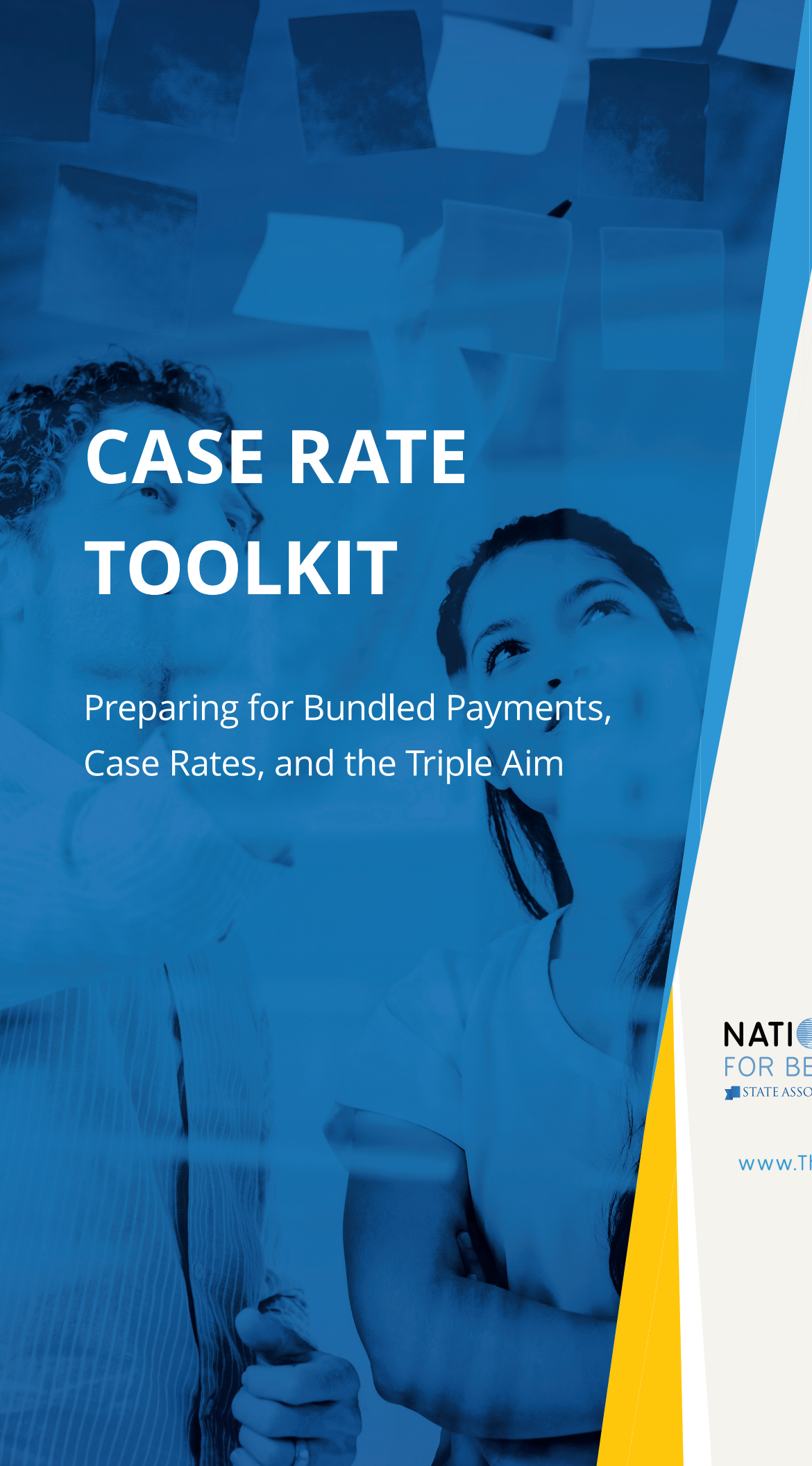

CASE RATE TOOLKIT

Preparing for Bundled Payments, Case Rates, and the Triple Aim

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OVERVIEW

The Case Rate Toolkit is a companion document to *Creeping and Leaping from Payment for Volume to Payment for Value: An Update on Behavioral Healthcare Payment Reform.*

Creeping and Leaping provides an overview of the behavioral health landscape, offering insight into how payment models are moving away from paying for volume to paying for value, and how behavioral health payment and service delivery models are evolving to align with the new definition of value.

The Case Rate Toolkit was written to help specialty behavioral health providers prepare for bundled payments/case rates, providing step by step guidance on how to convert from a fee-for-service payment model to this new approach. In this toolkit you will learn four practical pieces of information.

- What is a Bundled Payment? What are Case Rates? And Why are they Important?
- What Case Rates are NOT
- How to Set Case Rates
- How to Manage Under Case Rates

Read on and get ready for the future!

WHAT IS A BUNDLED PAYMENT? WHAT ARE CASE RATES? AND WHY ARE THEY IMPORTANT?

There is an emerging consensus that primary care and specialty care require different payment models to properly align the money with the expected outcomes. In the near future, community behavioral health center staff will either work as part of a team in a health home or as part of the workforce of a specialty behavioral health center of excellence.

The emerging payment model for specialty care, including specialty behavioral health, is Bundled Payments/ Case Rates. A Bundled Payment is another term for a Case Rate. Yes, having two names for the same model is confusing. For the rest of this paper I'll just use the term Case Rates.

Case Rate Definition: A Case Rate is a single payment to cover the costs of a "case". Let's make this definition a bit longer: A Case Rate represents a predetermined amount of money paid to a provider organization to cover the average costs of all services needed to achieve a successful outcome for a given defined episode of care for an individual over an agreed upon time period. (That's a mouthful!)

Example: We will pay you $3,500 for six months to provide community-based, recovery-oriented services for an adult mental health consumer who requires LOCUS Level 3 services. Your part of the bargain is to work with the consumer to develop a recovery-oriented professional care plan and self-care plan, identify at least one clinical goal and one personal goal, use a validated measurement tool to track progress on the clinical goal, work toward the agreed upon outcomes, change the care plan as needed, and get high marks on your customer satisfaction survey. Simple, right?

Case Rates are Important for Two Main Reasons

1) Case Rates provide much greater flexibility to the provider and consumer regarding who provides services, what is provided, and where services are provided – the consumer and provider decide and have more flexibility about what's needed.

2) Case Rates have a two-part value equation built into the process. First, if a care team selects a package of services for a consumer that is more cost-effective than other alternatives and achieves the desired outcome, the episode's actual cost may be lower than the case rate payment. This allows the provider to earn what some describe as a 'value bonus'. The second 'value lever' is to remove waste (excess cost) through lean process improvement activities, and achieve a lower unit cost than what was built into the case rate.

This agility and value is possible because Case Rate amounts are generally set based on the average number of units of service paid at an average rate per unit. If you can achieve good outcomes with fewer units at a lower cost, you earn a value bonus.

Note that Case Rates can also produce a reduction in administrative costs, when compared to fee for service. Although payors will require the submission of encounters under a Case Rate system, providers do not have to manage the intricacies of primary and secondary billing cycles for services provided to enrollees of a payor that pays Case Rates.

WHAT CASE RATES ARE NOT

Before we move on to learning how to create Case Rates, we need to cover a brief but very important topic – What Case Rates are NOT.

Case Rates are NOT a fixed budget for an individual consumer. Case Rates are an AVERAGE payment for all consumers served at a given level of care. By definition, some individuals will require MORE care at a given Case Rate Level and some will require LESS care to achieve the intended outcomes. Case Rates provide flexibility to the provider and consumer, not lock them into a rigid box.

The following example illustrates this important point for 1,110 consumers assigned to what I'm calling Level of Care B. In my example Level of Care B is part of a four-level system. (More about Levels of Care below.)

Level of Care B: Service Hours per Episode	# of Clients	Minimum Hours	Maximum Hours	Average Hours
Cohort 1: Low Utilization	239	4	10	8.0
Cohort 2: Medium Utilization	418	11	30	20.0
Cohort 3: Medium High Utilization	251	31	50	40.0
Cohort 4: High Utilization	202	51	110	65.0
TOTALS	**1,110**			**30.1**

Based on analysis of services provided to the 1,110 consumers, I have created four utilization cohorts: 4-10 hours; 11-30 hours; 31-50 hours; and 51-100 hours. Note the wide range of actual hours provided to the consumers within a single level of care – between 4 hours and 100 hours.

This variation is due to several factors including:

1) A number of consumers did not finish a complete course of treatment;
2) Some consumers were in a pre-contemplation phase and were not ready for a dense dose of treatment;
3) The level of care was broad enough so some consumers' full care plan required less service than others;
4) Some clinician caseloads were too high and they were unable to provide all of the care in the care plan; and
5) Some consumers received more care than needed to achieve the desired outcomes.

Although some of these reasons are less than desirable and improvement efforts should be made to address them, this is the reality of the current environment. What's most important is that once you address the problems and people get what they need to achieve their identified outcomes, a necessary range of service hours is provided to consumers within a given Level of Care.

HOW TO SET CASE RATES

Let's move on to examining how the rate setting process works for Case Rates. Once you understand how the payment model is constructed, you can complete a parallel process inside your organization to manage under case rates, which is covered in the next section, How to Manage Under Case Rates.

The following eight-step process uses the example of a regional Medicaid Mental Health Plan, Admirable Mental Health Partners. Admirable is setting case rates for community-based specialty mental health services. Once they have completed this work, they will use a similar process to set Case Rates for psychiatric inpatient, residential treatment, and possibly other episodic mental health services.

Let's now walk through each step.

SETTING CASE RATES: EIGHT STEPS AT-A-GLANCE

Step 1 Define the Population

Step 2 Estimate the Penetration Rate

Step 3 Define the Categories of Care/Episode Types

Step 4 Estimate the Case Mix

Step 5 Estimate the Utilization at Each Level of Care

Step 6 Estimate the Cost per Unit of Service

Step 7 Run the Calculations and Set the Case Rates

Step 8 Identify the Performance Metrics

Step 1: Define the Population

Admirable Mental Health Partners serves 30,000 Medicaid enrollees across a four-county region. The population age range includes newborns to elderly adults, who are assigned to a number of Medicaid eligibility groups that include Medicaid expansion, non-disabled traditional Medicaid, and disabled traditional Medicaid.

Admirable provides a broad set of mental health services to those Medicaid enrollees with a serious mental illness or serious emotional disturbance. Enrollees with mild and moderate disorders are covered under the physical health plan. Admirable has several years of utilization data for all but the Medicaid expansion population.

KEY VARIABLE 1: Medicaid Enrollees

Medicaid Enrollees	30,000

Note: A common practice is use different Case Rates for Youth/Adolescents and Adults/Older Adults. This example has been simplified to better illustrate the process.

Step 2: Estimate the Penetration Rate

Admirable must use historical data to estimate how many of the 30,000 enrollees will experience a serious mental illness or serious emotional disturbance and need community-based specialty mental health care. Since one can never predict the future with great precision, it is important to identify a range. This metric is called the Penetration Rate.

KEY VARIABLE 2: Penetration Rate and Cases for 30,000 Enrollees

	Low Rate	Medium Rate	High Rate
Penetration Rate	9.0%	10.0%	11.0%
Number of Cases	2,700	3,000	3,300

Note: For the remainder of the example, we are using the Medium Penetration Rate of 10% and 3,000 cases to simplify the explanation.

Step 3: Define the Categories of Care/Episode Types

For Medicaid enrollees with a serious mental illness or serious emotional disturbance, Admirable has organized their benefit package into the following categories, each with a designated payment method.

Continuum of Care		Payment Method
1	Call Center	Capacity Funding
2	Outreach Services	Capacity Funding
3	Prevention and Education Services	Capacity Funding
4	Wellness Center	Capacity Funding

Continuum of Care		Payment Method
5	Community-Based Services	Case Rate
6	Flex Funds	Fee for Service
7	Mobile Crisis	Capacity Funding
8	Urgent Walk-In Clinics	Capacity Funding
9	Crisis Respite	Per Diem
10	Home-Based Stabilization	Per Diem
11	Sub-Acute	Case Rate
12	Community Hospital	Case Rate
13	State Hospital	Per Diem

Since we are developing Case Rates for the Community-Based Services category (item 5), Admirable has drilled down into this category to develop four levels of care that are paid different Case Rates.

Level	Community-Based Services Level Description
Level A	Recovery Maintenance and Health Management (generally crosswalks to LOCUS Level 1)
Level B	Low Intensity Community Based Services (generally crosswalks to LOCUS Level 2)
Level C	High Intensity Community Based Services (generally crosswalks to LOCUS Level 3)
Level D	Wraparound ACT-Level Care (generally crosswalks to LOCUS Level 4)

Step 4: Estimate the Case Mix

In order to create Case Rates, we will estimate how many people are served at each level of care. Fortunately, Admirable has a long history of utilizing the LOCUS Level of Care tool for Adults and the CALOCUS for youth. This will greatly improve the quality of the case mix estimation process. If no such tool was in use, Admirable would have had to look to other communities for case mix figures and analyze historical utilization levels within the Admirable enrollment base.

KEY VARIABLE 3: Case Mix

Level	Description	Mix
Level A	Recovery Maintenance and Health Management	20%
Level B	Low Intensity Community Based Services	37%
Level C	High Intensity Community Based Services	33%
Level D	Wraparound ACT-Level Care	10%
Totals		**100%**

The above table translates into the following sentence: Based on historical information, 20% of the cases are expected to be served at the lowest level of care for the population; 27% at a low-medium level of care, 33% at a high-medium level of care, and 10% at the highest level of community-based care.

Step 5: Estimate Average Utilization at Each Level of Care

We have created multiple levels of care to ensure that organizations serving more higher-need cases receive more money, and organizations serving more lower-need cases receive less money. Just think what would happen if provider organizations received the same Case Rate regardless of the level of need. There would be a huge incentive to "cherry pick" low need cases; a term called "adverse selection". We want to remove this incentive and, if anything, create a financial incentive to serve more complex cases.

Again, having historical data has helped Admirable estimate the average utilization at each level of care, as illustrated in the following table. If they did not have historical data, Admirable would look to other communities or convene an expert clinical panel to estimate these figures.

KEY VARIABLE 4: Average Hours per Level

Level	Description	Minimum Hours	Maximum Hours	Average Hours
Level A	Recovery Maintenance and Health Management	1	30	10
Level B	Low Intensity Community Based Services	15	100	30
Level C	High Intensity Community Based Services	20	160	80
Level D	Wraparound ACT-Level Care	50	240	110

We're getting close to computing the Case Rates and the Total Case Rate Budget. We have estimated how many people will need community based care, the distribution of cases across levels, and how much care the average person will need at each level.

Step 6: Estimate the Cost per Unit of Service

In a mental health outpatient system, the two main direct cost variables are clinician type and visit duration. This makes sense because a psychiatrist has a higher salary than a peer counselor, and a 15-minute psychiatry visit costs less than a 75-minute visit.

The best way to estimate the cost per unit of service is to gather historical data on all the service codes, the average length of each visit, and include the mix of clinician types who provided the service. These data are then used to estimate the Average Cost per Hour, which is the basis of this Case Rate model.

The following table provides a glimpse of the type of historical data that's used for this type of analysis. In this example, when all services by clinician type are compiled, the average cost per hour is $158.62, even though costs range from $55.50 to $331.30.

Code	Description	Prescriber	RN	Masters Level	Below Masters Level	Billed per Hour
90801	Psychiatric Diagnostic Interview	35%	0%	65%	0%	$260.36
90804	Individual psychotherapy	0%	0%	100%	0%	$151.25
90806	Individual psychotherapy	1%	0%	99%	0%	$151.25
90847	Family psychotherapy	0%	0%	100%	0%	$137.42
90853	Group psychotherapy	0%	0%	100%	0%	$275.72
90862	Pharmacologic management	100%	0%	0%	0%	$234.04
H0004	Behavioral Health Counseling	0%	0%	100%	0%	$144.21
H0036	Community Supportive	25%	0%	18%	57%	$55.50
H2010	Medication Services	0%	79%	21%	0%	$331.30
H2014	Skills Training/Development	0%	0%	25%	75%	$90.77
Total						**$158.62**

Generally, the overall average cost per hour is moved forward to the next step.

KEY VARIABLE 5: Rate per Hour

Rate per Hour	$158.62

Note: There are instances where the service mix at different Levels of Care is quite different. For example, consumers served at one level might have much more prescriber time than consumers served at another level. This may require setting different average rates per hour for each level of care.

Step 7: Run the Calculations and Set the Case Rates

The following two tables are the result of steps 1-6. The first table shows the Case Rate figures and the second table computes a total annual budget for Admirable's community-based services.

Level	Description	Average Hours	Rate	Case Rate
Level A	Recovery Maintenance and Health Management	10	$158.62	$1,586
Level B	Low Intensity Community Based Services	30	$158.62	$4,759
Level C	High Intensity Community Based Services	80	$158.62	$12,689
Level D	Wraparound ACT-Level Care	110	$158.62	$17,448

Note that the average hours per case are multiplied by the average rate per hour to determine the Case Rate. It's that simple!

The total budget is computed in a two-step process: 1) The total number of cases (3,000) is spread across the levels based on the estimated case mix. 2) The number of cases at each level is then multiplied by the case rate to determine the total costs. It's really that simple!

Description	Case Mix	Cases	Case Rate	Total Costs
A: Recovery Maintenance/Health Management	20%	600	$1,586	$951,704
B: Low Intensity Community Based Services	37%	1,110	$4,759	$5,281,959
C: High Intensity Community Based Services	33%	990	$12,689	$12,562,497
D: Wraparound ACT-Level Care	10%	300	$17,448	$5,234,374
Total	**100%**	**3,000**		**$24,030,535**

But remember, these are only estimates. Admirable will need to create a risk reserve on top of the $24 million, just in case reality unfolds differently. They will also need to track penetration and case mix carefully throughout the year to make sure that any increase in penetration or case mix doesn't lead to actual expenditures that are greater than available funds.

Step 8: Identify the Performance Metrics

Since Admirable is moving away from a volume based payment model (fee for service), they will identify the performance metrics to ensure that provider organizations are meeting the needs of consumers.

Although a thorough understanding of this topic requires a separate paper, let's dip our toes in the water. Following are a handful of minimum performance metrics that might be considered.

Measure	Monitoring Method(s)	Frequency
1) Submission of encounter data for 100% of services provided, including "flexible" services.	Review of encounters versus payments. Retrospective encounter validation reviews/ chart reviews.	Quarterly
2) Meet access standards (14 days for routine, 48 hours for urgent, same day for emergent).	Provider access reports. Secret shopper calls. Consumer and partner feedback.	Quarterly
3) Provide follow up appointment or clinical contact to consumers within 7 days of discharge from acute care.	Claims data review.	Monthly
5) Agreement on Level of Care Assignment.	75% agreement on the LOC assignment based on a concurrent review.	Ad Hoc
6) Services align with the Level of Care Assignment.	75% of consumers are receiving the intensity of service that's within the LOC range; concurrent review.	Monthly
7) Delivery outcomes-based care based on agreed upon standards.	Concurrent and retrospective review.	Monthly Review

HOW TO MANAGE UNDER CASE RATES

Zontanos:
Ancient Greek for *Alive.*

We are going to build on the *Admirable Mental Health Partners* example to explain how to manage under Case Rates. Your organization, *Zontanos Health and Wellness,* is a mid-sized community mental health center that provides services in three of the four counties covered by Admirable. You have a 33% share of the market, and provide community-based mental health services to 1,000 consumers per year. Zontanos has a strong management team including innovative clinical leaders, and nimble directors of finance and information technology. You may not be the biggest center, but you are among the best.

Although you have never operated under Case Rates, you have done your homework and have designed a Case Rate Readiness Plan consisting of three components:

- Part A: Clinical Design
- Part B: Clinical-Financial Modeling
- Part C: Implementation and Ongoing Operations

Part A: Clinical Design

Knowing that the work begins with clinical design, Zontanos has created a Clinical Design Team to complete the following steps. Since time is of the essence and adjustments will be needed, the design team has an aggressive timeline for their work.

Step A1: Assessment and Level of Care Design

The design team understands the importance of assigning a proper Level of Care. They realize that their payor, Admirable, has developed a Level of Care System with four levels, but have questions about the assessment and assignment approach they will use internally. The organization has used the LOCUS and CALOCUS for a number of years and there's a robust debate about its inter-rater reliability; some think it is "good enough", others not.

Their solution is to create a two-part experiment. Some of the clinical teams will continue to use LOCUS/CALOCUS. Other clinical teams will pilot the DLA-20 functional assessment tool, creating a crosswalk to the four levels of care. Their goal? To test the ability of the two tools to ensure that consumers, regardless of differences in their history, diagnoses, functional status, complexity, community supports, cultural background and engagement level, are assigned a Level of Care that corresponds to their readiness and need. This, they conclude, is how a Learning Organization should operate.

Step A2: Evidence-Based and Promising Practices Research

Now that the clinical team has taken a fresh look at the Levels of Care, they turn their focus to the evidence-based and promising practices used both inside the organization and around the world. This mini-research project begins with answering the question: "Who are the people we serve and what does the literature say about what works for them?"

To accomplish this task they join the PracticeWise community, a web-based resource for "what works in children's mental health" (www.practicewise.com); and tap into the SAMHSA National Registry of Evidence-Based Programs and Practices (www.nrepp.samhsa.gov). This modest effort triples the evidence-based practices that can be added to Zontanos Clinician's Tool Kit.

Knowing that they don't have the resources or funding levels to support the development, training, and ongoing coaching and related costs for this number of EBPs, they come up with a brilliant idea for Step A3.

Step A3: Clinical Intervention Design

The Clinical Design Team has enough experience with EBPs to know that specific clinical interventions are used in multiple EBPs. This leads them to deconstruct their desired EBPs and compile the interventions embedded in each. They create a table where the EBPs are listed in the columns and the interventions used in each EBP are listed in the rows, with check boxes that designate the interventions related to each EBP. Sure enough, they are able to identify a reasonable list of interventions for the organization.

Their next step is to crosswalk the interventions to the Levels of Care, developing a menu of interventions that should be available at each Level of Care. They decide that this step is a necessary piece of guidance to support clinicians in developing the right care plan for consumers at a given Level of Care.

Finally, the design team identifies the gaps between their Clinician's Tool Kit and what should be included, and they create a two year plan to train clinicians on the relevant interventions for the consumers each clinician serves.

Step A4: Utilization Management Guidelines

The Clinical Design Team is now ready to move out of their comfort zone to accomplish the next task – developing internal utilization management guidelines. These guidelines are the range of service hours and duration of care that generally correspond to each level of care. Clinicians are expected to design care plans for their consumers that fit within the guidelines most of the time. Approval protocols are also developed for when a clinician feels that a treatment plan should contain fewer or more services than expected for a given level of care.

The purpose of internal utilization management guidelines is to help ensure that consumers with lower need receive, on the average, care plans of less intensity than consumers with higher need, based on the theory that "right sizing" care (not too little, not too much) is a component of providing high-value, outcome-based care.

These guidelines are created by balancing what the payor is paying for each Level of Care and assessing the needed intensity and duration of the interventions on the menu for each Level of Care. The following table illustrates what the results might look like.

Level	Description	Low End	High End	Average
Level A	Recovery Maintenance and Health Management	5	15	10
Level B	Low Intensity Community Based Services	10	50	30

Level C	High Intensity Community Based Services	50	110	80
Level D	Wraparound ACT-Level Care	80	140	110

Step A5: Outcome-Based Care Model Design

The Clinical Design Team has done their homework about the Treat to Target model that is adopted throughout the country and decided that it is an essential ingredient of their success. There are six components to treat to target and clinicians at Zontanos are generally using some, but not all components.

1. Organize into multi-disciplinary care team.
2. Complete a multi-dimensional assessment and diagnosis for each consumer.
3. Develop evidence-informed care plan and self-care plan for each consumer.
4. Identify measurable "targets" for each consumer based on readily available instruments such as PHQ-9 for Depression, MDQ (Mood Disorder Questionnaire) for bipolar disorder, and GAD-7 (Generalized Anxiety Disorder-7) for anxiety.
5. Measure frequently; this may mean every visit for some measures.
6. If targets are not met (e.g. our PHQ-9 score didn't come down to the target number in 30, 60 or 90 days), change the care plan and/or self-care plan.

The team decides that this approach to outcome-based care will become the expectation throughout the organization and identifies the tools currently used and identifies tools that should be added.

At this point the Clinical Design Team has the makings of a multipart Clinician's Tool Kit that includes EBPs that are used when relevant, practical and affordable; clinical interventions; utilization management guidelines; a Treat to Target framework; and tools to track progress on clinical measures.

Step A6: Training and Coaching Program

The Clinical Design Team completes their design work by creating a twelve-month training and coaching program that is organized around the Clinician's Tool Kit, embedding the new expectations into the clinical supervision process.

Part B: Clinical-Financial Modeling

Running parallel to the Clinical Design process, a Clinical-Financial Modeling Workgroup is assembled to design the foundation of the Case Rate measurement and reporting system and then prepares for feasibility testing of the Clinical Design Team's work.

Step B1: Clinical-Financial Model Development

The workgroup begins with the development of an Excel-based Clinical Financial Model. This includes the following sections.

1) **Consumers and Consumer Mix:** This section is organized to test multiple scenarios of the number of consumers they serve each year and what the case mix might be (how many people at each level of care). This mirrors Steps 2 and 4 of the "How to Create Case Rates" section above.

2) **Service Hours:** This section allows the organization to test multiple scenarios of average hours that are provided at each Level of Care, mirroring Step 5 of the "How to Create Case Rates" section.

   Note that some organizations dig deeper into their analysis to identify sub-levels of care within each Level of Care.

3) **Caseload Sizes:** The Clinical-Financial Modeling Workgroup found a Caseload Tool on the web to help set caseload size standards for each clinician or clinical team, based on the case mix of each clinician or team. This is based on the reality that if Clinician X has a caseload of consumers that are all Level C (80 hours per average case), they will serve fewer cases than Clinician Y, who has a caseload of consumers that are all Level A (10 hours per average case). (www.djconsult.net/resources-1/case-rate-info)

4) **Full Time Equivalents:** A section is developed that uses data from Steps 1-3 to estimate how many service delivery Full-Time Equivalent staff are needed for each scenario, compare this with how many staff FTEs are currently on the payroll, and identify staffing gaps for each scenario.

5) **Staffing Costs:** This section adds staff salaries, wages, benefits, payroll taxes, and contractor fees for both direct service staff and other staff.

6) **Overhead Costs:** This section is the place to enter all non-staff costs including occupancy, supplies, travel, training, depreciation, working capital, etc.

7) **Projected Revenue:** This section draws from the Consumers and Consumer Mix section, adding Case Rate revenue per case plus fee-for-service billings from other payors, grant revenue, fundraising revenue and other revenue.

8) **Capacity/Demand and Revenue/Expense Dashboard:** All of the information from Sections 1-7 is summarized in a dashboard that provides an at-a-glance view for answering two questions: Have we balanced the number of available clinicians with the services we plan to provide? Do our revenues balance with our expenses?

The model is now ready to balance capacity and demand, and revenue and expense.

Step B2: Clinical-Financial Modeling

The Clinical Design Team and Clinical-Financial Modeling Workgroup are brought together to participate in a series of 2 4-hour work sessions to test the feasibility of the clinical design and to further refine the design. The work sessions are organized as small group exercises with six staff at a table equipped with a computer containing the Clinical-Financial Model that is loaded with inputs from the clinical design.

It turns out that the first draft of the design doesn't balance. Too many hours are projected, which requires hiring too many new clinicians, which generates more expense than the case rates will cover. It's the job of

each small group to test out changes to the clinical design (case mix, hours per case, staff mix, costs, etc.). These changes should be tested one-by-one, going to the Dashboard after each test, to determine if the change helped the out-of-balance situation and by how much. The theory is, if you are out of balance, making several small tweaks is a better way to achieve balance than imposing one or two large-scale changes.

The groups come back together, share their findings and work together to identify the "sweet spot" of design changes that maintain the integrity of the clinical design and balance the budget. As mentioned above, this is accomplished over multiple work sessions so participants have time to soak in what they're learning and complete additional research.

Step B3: Clinical-Financial Tracking System Design

Running parallel to Steps B1 and B2, financial and information technology staff are tasked with studying the Clinical-Financial Model and Clinical Design to identify the reports needed at the clinician, supervisor, manager and leadership team levels to track how reality unfolds. These reports fall into two categories: Clinical Tracking Reports and reports that translate the Clinical-Financial Modeling tool into monthly utilization and financial reports.

Once the first draft of the reports are designed, the Tracking System Workgroup determines what gaps exist in the current infrastructure to capture and report on needed data, identifies short-term strategies for closing gaps quickly, and identifies longer-term strategies for more permanent solutions. They then need to develop short and long-term work plans to make it happen. The short-term goal is include stopgap solutions within 90 days to support management under the new system.

Part C: Implementation and Ongoing Operations

Information from Parts A and B are combined into a set of implementation plans that are affordable and realistic. Systems will need to be developed and lots of training and coaching will be necessary. Many staff may stop doing some tasks and start doing new tasks.

Change management skills are also required and must be well tuned to the culture of the organization. Staff involvement and empowerment are critical to success. The entire project should be organized through a continuous quality-improvement framework that uses Rapid Cycle Improvement methods to bring about change that becomes real improvement. No small feat for most organizations.

The organization will need to monitor the case rate hours and dollars monthly to determine if reality is unfolding as expected. If there are too few FTEs and/or if too few services are provided, expected outcomes may not be achieved, including consumers not hitting their clinical targets. If too many services are provided with too many FTEs, the agency may lose money. Zontanos will likely adjust the system more than once based on analysis of problems identified during the monitoring process.

CONCLUSION

We hope this material provides enough detail about Case Rates to create a glide path to a behavioral health payment reform future. If your payor(s) are contemplating payment reforms, they probably will consider using Case Rates and this paper may be quite timely.

If your payors aren't moving to case rates, take the initiative and design a case rate system with your colleagues and then pitch it to the payors.

If you are providing services in a community where the payors don't know about Case Rates, it may be time to take the initiative. If, for example, a group of providers get together and design a Case Rate system following the guidance in this paper, the provider group could present their design to the payor(s). The pitch would be: "We can help you move from paying for volume to paying for value, thereby increasing your value to the purchaser who pays you to manage the system."

Another alternative is to organize internally to succeed under a case rate model while remaining in fee for service. Though not ideal, wouldn't it be great to be fully ready when your payors finally realize that bundled payments/case rates are the future, and the future is now?

In any event, remember that the key ingredients include learning about Bundled Payments/ Case Rates; ensure that your clinical services deliver outcomes-based care; and revise your billing, financial reporting and data tracking systems to fit the new payment model.

Best wishes, keep the needs of your consumers first, and don't forget to keep learning and have fun!